



# REGISTRATION

## I. Demographic Information

Full Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apartment/Unit#: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Main Phone #: \_\_\_\_\_  
Secondary Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

### Race:

- American Indian/Alaska Native Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander White
- Other
- Prefer not to answer

### Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Prefer not to answer

### Gender:

- Female
- Male
- Other (specify) \_\_\_\_\_

### Do you consider yourself to be?

- Heterosexual or straight
- Homosexual
- Bisexual
- Prefer not to answer

### Primary Language:

- English
- Spanish
- Other (specify) \_\_\_\_\_

### Insurance Information:

\_\_\_\_\_  
Name and ID # of Insurance

\_\_\_\_\_  
How many people live in your

\_\_\_\_\_  
household?

Uninsured

## II. Current Symptoms

Are you currently having symptoms of Covid-19?  
(select all that apply)

- No
- Fever or chills
- Cough
- Shortness of breath / difficulty breathing
- Muscle / body aches
- Pneumonia
- Bronchitis
- Runny nose
- Loss of taste/smell
- Sore throat Nausea
- Vomiting
- Diarrhea
- Chest pain
- Abdominal pain
- Other (specify) \_\_\_\_\_

## III. Medical History

For females only--Are you currently pregnant?  Yes  No

Do you have the following risk factors? (select all that apply)

- 65 or older
- Diabetes
- Asthma
- COPD
- History of stroke
- History of heart attack
- High blood pressure
- Cardiac condition
- HIV/AIDS
- Chronic kidney disease
- Liver disease
- Cancer or leukemia/multiple myeloma
- Smoker
- Obesity

Have you ever been told that you have coronavirus-19?

Yes  No If yes, when \_\_\_\_\_

#### IV. Awareness

How did you learn about the testing program?

- From the internet
- From the radio
- From a Flyer
- Word of mouth
- From a healthcare provider

#### V. Release and Signature

I certify that my answers are true and complete to the best of my knowledge. I understand that I will be scheduled for a telehealth appointment within 5 days for my results.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PrintName: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

I agree that my test results can be released for the purpose of informing me about the results.

Yes  No

### CONSENT FOR MEDICAL SERVICES

**I hereby consent to receive medical services from Aunt Martha's Center.** I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, insurance companies, Reviewing and Accreditation organizations and other Aunt Martha's programs.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Date